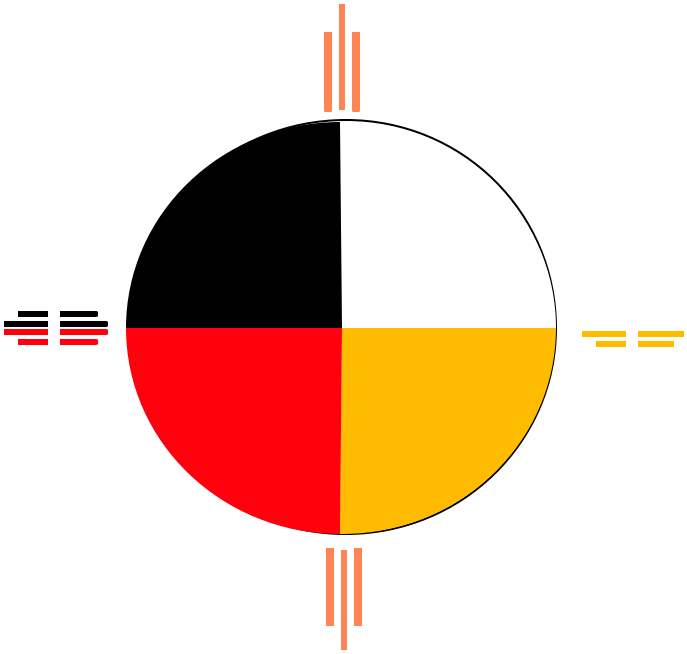
Design for a New IHS



Final Recommendations of the Indian Health Design Team

Report Number II
January 1997

Chapter
1

INTRODUCTION

Purpose

The purpose of this report is to provide the final recommendations of the Indian Health Design Team (IHDT). In November 1995, the IHDT provided a report titled, "Design for a New IHS," to Indian Country and the Indian Health Service (IHS). This report, our second, takes into account progress in implementing our initial recommendations and additional feedback regarding restructuring of IHS.

Our second report focuses on the following issues:

- We describe more fully what we mean when we say that we want an IHS that supports health care at the local level – *Chapter 2: Our Vision for Change*.
- We provide additional guidance on the implementation of our recommendations for changing IHS Headquarters – *Chapter 3: Changes at Headquarters*.
- We give new recommendations for changes of IHS components at the Area level – *Chapter 4: Changes at Area Offices*.
- We consider recommendations for changes to Urban Indian Health – *Chapter 5: Urban Indian Health*.
- We describe the feedback on our recommendations that we received from Indian Country -- *Chapter 6: Feedback and Response*.

Background

Indian people, tribal leaders, and IHS employees have guided this design process through the IHDT to ensure the recommendations reflect the diverse perspectives and address the health needs of all Indian people. Our role is to guide the process and make sure that it includes a way to get our work out to the primary partners for review and feedback.

Our reports were distributed widely to get your feedback. Reports and newsletters were mailed to over 1,000 tribal leaders, tribal organizations, urban Indian health program directors, National Indian Health Board (NIHB) Area health boards, and tribal health directors. Draft recommendations also were mailed to IHS Area Directors and service unit directors for further distribution to their employees and to Indian communities. The IHS Headquarters offices at Rockville and Albuquerque distributed our initial recommendations to employees

desk to desk. The report also was available to approximately 12,000 employees by the Agency-wide electronic mail network. It was available on the world wide web computer network for access by anyone with a computer. It was available on request from the IHS Headquarters offices, Area Offices, and the NIHB. The IHDT members gave reports in their communities and to tribes throughout Indian Country. We provided ways for the feedback to be received by postal mail, by fax, by electronic mail, and by telephone. The feedback was considered to assure our recommendations reflect a partnership viewpoint.

In February 1996, we held a Tribal Leaders Forum in Albuquerque, New Mexico, so that tribal representatives could talk to IHDT members and the Director, IHS, about our recommendations and how we should continue. The process used to develop the recommendations was the first attempt in 40 years to change the overall structure of the IHS. It was the first time that Indian people guided and participated in designing a new health care system that works better for us.

Area Design Workshops in 1996

After the February 1996 Tribal Leaders Forum, we decided that the next step in designing changes at the Area Office level should include more involvement from the Area and community level. We decided not to establish a national implementation team to do the work for the Areas. We gave a suggested format to the IHS Area Directors and asked them to lead the effort and hold Area workshops with tribal leaders, tribal health and urban Indian health directors, and IHS employees. The IHDT members attended and participated in the workshops in their respective Areas. In the July 1996 meeting, we reviewed the Area workshop results.

Our initial report suggested consolidating Area level functions into regional support centers. However, consolidation of 12 Area Offices into 3 regional support centers was not widely supported by the Area level workshop participants or in other feedback from Indian Country. Because the Area level support system is stretched thinly in several Areas, we considered other ways to restructure these components. Our revised recommendations for restructuring Area level components are presented in Chapter 4.

Where To Go From Here

The change process is at a transition point - a point where the Areas, I/T/Us (an acronym that means local Indian health programs whether operated directly by the IHS, or by a tribe or tribal organization, or by an Urban Indian Health Program) and Indian communities will take a more active role in guiding the change locally.

It is not a time in Indian Country to sit back and breathe easy. We cannot tolerate too many missed opportunities. The internal and external forces that are putting pressures on our health care systems have not gone away since we published our November 1995 report. We seek to empower the local level to determine and act on the change that is needed to better serve Indian Country. If we do not act to make changes, we run a risk that someone else will do it for us - maybe in ways that are not in our best interests.

Chapter
2

OUR VISION FOR CHANGE

In our November 1995 report, we propose 50 ways to change the IHS into a new organization committed to serving our people and improving their health. Our report put forth ideas for changing both the IHS structure and for new ways of performing within that structure. That new way of doing business is to support the I/T/U and empower it to meet the health care needs of its service community. In this chapter we describe more fully what we mean when we say that we want an IHS that supports health care at the local level

The Early Organization

The IHS was established by legislation in 1955. Since then, the IHS has improved the health status of our people. We are grateful for these improvements. However, problems now faced in Indian Country are different than they were 40 years ago and the pace of health improvements has slowed because our health problems have changed.

We believe that the IHS as it was set up in the 1950s is not the best way to respond to the current problems or future problems. When the IHS system was established, most government programs were set up as hierarchies that controlled things from the top down. At the time, there was no alternative to centralizing some of the work. Because most Indian hospitals and health centers were small, they could not afford to do everything alone. Area Offices were set up to help do this work. Since then, local capabilities have progressed. New technology and communications provide new alternatives for organizing the system and for doing work. The time is right for a new approach.

Support System for I/T/U

After studying the problems, the members of the IHDT concluded that one design could not fit all the hospitals and health centers in Indian Country. The differences among them are too great. We decided to focus on restructuring the support system on which hospitals and health centers depend for work not done onsite. The IHDT members considered how to supply the support services needed by hospitals and health centers. Most of the ideas relate to how IHS Area Offices and Headquarters should change to get this work done more effectively and at less cost.

Empowering the Local Level

The idea of local empowerment is one of the key changes that members of the IHDT seek. The main point is that the people closer to you are more likely to address your needs than

someone far away. One problem with the centralization of work is that decisions are made far from where health services are provided. Even when decision makers are skilled and devoted to your interests, as IHS staff are, they are not as familiar with local issues as local health staff. Placing ownership and responsibility close to the work is very important to the change we seek. Local officials can respond more quickly and flexibly to needs in your community.

From Control to Support

IHS hospitals and health centers were set up as subordinates of Area Offices when the IHS was established. It has been said that real authority and resources rested with the Area Office and flowed downward through the hierarchy to the service unit. While this approach provides some economies of scale, it limits choice and flexibility at the local level.

The new relationship will be built on empowering the local I/T/U to choose how and where to get those support services it can not do alone. If an I/T/U chooses not to use it's traditional Area Office or Headquarters source, the I/T/U should be free to get support services from another source. Under this approach, Headquarters and Area Offices must become suppliers to I/T/Us. The role of service supplier replaces the old role of controlling and giving permission.

With more choice and flexibility comes more responsibility for the I/T/U. The I/T/U may choose a new source for support services such as personnel, finance, and procurement. It may choose to do this work at the I/T/U if that is practical. I/T/Us will learn that cooperation and collaboration will give them a bigger voice. The suppliers of service, including Area and Headquarters, will also learn to respect this voice.

Overcoming Risks

There are some risks that must be overcome. Today, many Indian hospitals and health centers are small and geographically isolated. Smaller Indian health programs do not have enough clout when acting alone. If each I/T/U attempts to do everything alone, costs could rise. For small remote I/T/Us, prohibitive costs could make many services impractical. Unless we cooperate to share capabilities and buying power, our programs risk rising operating costs, reduced leverage in negotiating prices, and becoming more vulnerable to competitors. To reduce these risks, Indian hospitals and health centers need to cooperate to share capabilities, leverage buying power, and create a bigger voice together.

Enabling Cooperation through an Indian Health Network

Today, advanced communications technology offers the possibility to connect together Indian hospitals and health centers located anywhere in the United States. As participants in an nation-wide Indian health network, each hospital and health center could access capabilities not available locally. By connecting each hospital and health center with other Indian health facilities and all Area Offices, local staff can choose among many options for getting support services. They could share support services available anywhere within the network and work together to increase buying power. For example, an Indian health center in Oregon could use an expert radiologist in an IHS hospital in Arizona to read X-rays. An Indian hospital in Arizona could manage payroll through a personnel function in Portland

Area. The limits of geographic location become less important and dependence on one source is reduced. In this way, Indian health programs can realize the benefits of cooperation, decrease dependence, and gain flexibility to fit local needs. The technology to do this exists. Investment in a nation-wide Indian health network is essential to achieving a level of collaboration necessary to offset risks related to geographic isolation and small size.

More Business-Like Practices

Concurrent with the structural changes that we envision, the IHS also must shift to a more business-like way of conducting internal operations. The Business Plan Workgroup is a team of IHS officials and Indian leaders appointed by the Director, IHS to identify improvements in IHS business practices. The focus on internal business practices by the Business Plan Workgroup was coordinated with the IHDT and complements the structural changes proposed in our report.

The Business Plan Workgroup proposed a business plan with changes in four key segments of IHS operations: ways to increase revenues through third party collections; ways to control cost increases and maintain financial solvency; ways to manage increasing transfers of IHS components and resources to tribes; and ways to bring other useful business-like approaches to internal management and operations. Like the restructuring plan, all of the features of the business plan can not be realized immediately. The plan ranks the proposals in priority order and identifies a timetable to accomplish recommended changes over a 2-3 year period. This report does not cover details of the business plan. These are described separately in a report by the Business Plan Workgroup titled *Business Plan for the Indian Health Service*.

The Role for Leadership

Refocusing leadership is a big first step toward achieving our vision for a new IHS. Our health care leaders should advocate for the whole Indian health system. They should foster cooperation and networking among I/T/Us without controlling daily operations at the local level. They should enable more opportunities and choices at the local level without dictating the decisions. And they should work to create a bigger voice for the whole of Indian Country.

We ask our health care leaders to be accountable for the outcomes of the Indian health program, without acting to control or take care of others. By letting go of that kind of care taking and control, we hold on to the spiritual meaning of empowerment -- to honor what has been entrusted to us and to act in ways to improve the health of our people.

Chronology of Key IHDT Activities

October 17, 1994	*Orientation for Indian health leaders on Designing a New IHS*
November15, 1994	*Patient/Customer Suggestion Questionnaire Distributed*
November 29, 1994	*"Designing a New IHS" Plenary Session, Albuquerque Convention Center*
February 8, 1995	*First formal meeting of the IHDT*
March 13, 1995	*Co-chairs brief the Senate Committee on Indian Affairs*
March 15, 1995	*IHDT Tier II workgroups orientation*
March 28, 1995	*Second formal meeting of the IHDT*
April-May, 1995	*Tier II workgroups conduct study and develop options*
May 24, 1995	*Tier II workgroups present options to IHDT*
June 8, 1995	*IHS Council of Area & Associate Directors endorse IHDT design concepts*
June 27, 1995	*IHDT meeting to select initial recommendations*
August, 1995	*IHDT DRAFT report distributed to Indian Country and IHS employees*
Sept.-Oct., 1995	*Comment and feedback*
October 10, 1995	*IHDT reviews and incorporates feedback into final recommendations*
December 1, 1995	*Design recommendations presented at NIHB Consumer Conference*
January 30, 1996	*Congressional Briefing on IHDT design recommendations*
February 14, 1996	*Tribal Leaders Forum, Albuquerque, NM*
February 15, 1996	*IHDT plans a new approach to design Area level changes*
March 19, 1996	*Training for Area staff to hold Area Design Workshops*
April-June, 1996	*Area Workshops with community leaders and I/T/U officials*
July 10, 1996	*Headquarters implementation design sent to IHDT*
July 23, 1996	*IHDT incorporates Area Workshop results into revised recommendations*
August 30, 1996	*Draft report of Area level recommendations distributed to Indian Country*
Sept.-Oct., 1996	*Comment and feedback*
Sept. 18, 1996	*Plenary Session and Forum at the NIHB 14th Annual Consumers Conference*
Oct. 9, 1996	*Final meeting of IHDT to revise recommendations for Area level change*
Nov. 13, 1996	*Headquarters reorganization package submitted to the Director*
Nov. 13, 1996	*Co-Chairs brief Congressional committees on recommendations*
Nov.-Dec., 1996	*Additional comment and feedback*
Jan. 31, 1997	*Final Report with revised recommendations for Area restructuring*

March 1, 1997	*Implement new Headquarters structure*
April-May, 1997	*Inter-Area workshops to identify cooperative arrangements for work*
August 30, 1997	*Complete Headquarters resources transfer*
Sept. 30, 1997	*Inter-Area cooperative sharing plans due*

Chapter

3

CHANGES AT HEADQUARTERS

We have recommended changes to the structure and functions of IHS Headquarters to bring leadership at the top in line with empowering the I/T/U. The key changes we seek are:

- Reduce layers and streamline Headquarters organizational structure;
- Delegate operational controls and field support activities to the field together with associated resources and staff; and
- Focus on core functions of advocacy for Indian health, leadership, empowerment to I/T/Us. Be a voice for Indian people and build partnerships with tribes. Document our health needs, support a nation-wide Indian health network, and maintain an Indian health data bank.

Reduce Headquarters Layers and Streamline Structure

To reduce layers and streamline structure, Headquarters has:

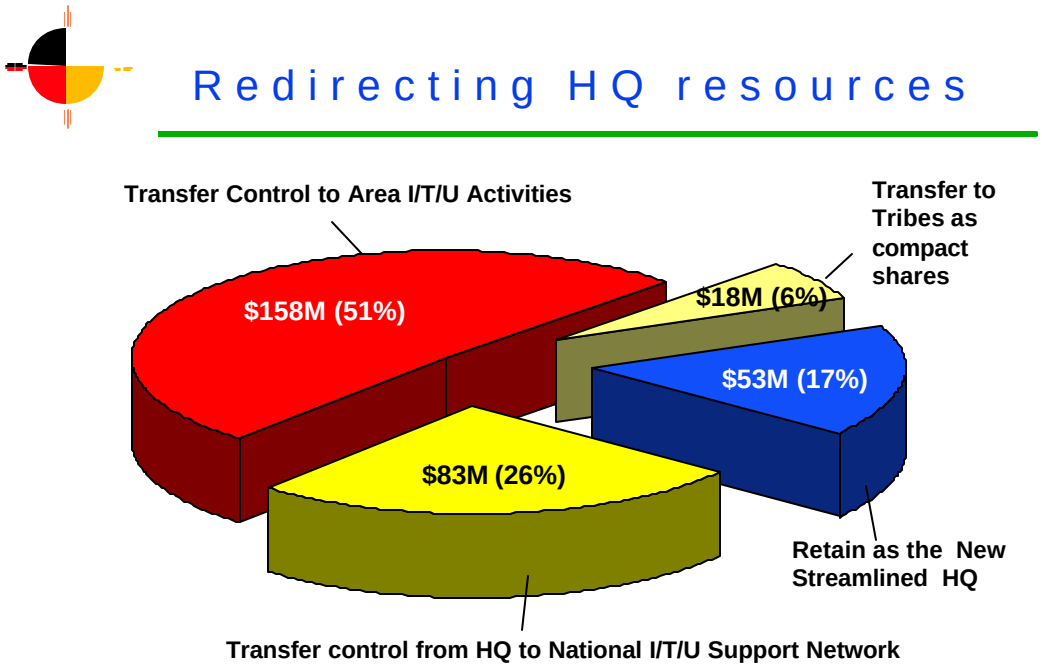
1) Consolidated its 8 major offices into to 3 major offices. The three major offices are:
   - *Office of the Director* (consolidates the Offices of the Director, Tribal Activities, Self-Governance, and Legislation),
   - *Office of Public Health* (consolidates the Offices of Health Programs, Environmental Health and Engineering, and Planning), and
   - *Office of Management Support* (consolidates the Offices of Human Resources, Administration and Management, and Information Resources Management).
2) Consolidated organizational units called divisions and branches from 132 to less than 50
3) Prepared organizational charts, defining office and staff functional statements, staffing patterns, and operating budgets to support the above changes.

We believe that Headquarters is moving in the right direction. The new streamlined structure is scheduled for completion in 1997. A number of Headquarters activities are being identified for transfer. We are looking forward to a streamlined organization with reduced numbers of supervisors and managers at Headquarters.

Transfer Functions, Staff, and Resources to the Field

In carrying out our recommendation to transfer functions, staff, and resources to the field, the IHS Headquarters is:

1) Identifying how control and responsibility for resources traditionally managed at Headquarters can be further decentralized. An estimated $312 million was managed by Headquarters in 1996. Using the 1996 numbers as a benchmark, one plan for redirecting Headquarters managed funds is shown in the chart below.



2) In previous years, the Headquarters managed budget paid for many support services for field operations (e.g., rent, communications, construction, etc.). These funds were often spent at the local level, but were shown in Headquarters managed accounts. Under the restructuring plan, only resources associated with core functions will be included in the Headquarters budget, about 17 percent of the former amount. The balance of funds formerly managed by Headquarters will be designated for public health support activities, transferred to Area Office control based on costs actually incurred, or transferred directly to tribal compacts and contracts that elect to assume responsibility for eligible Headquarters components.

3) Reducing Headquarters full time workers to 500 by September 30, 1996.

4) Transferring selected activities to the field. These activities (like those listed in #2 above) may continue in the field to the extent that they provide value that I/T/Us will support.

5) Planning for public health support (such as Indian health professions recruitment, technical assistance and training programs for alcohol, diabetes and information/computer development and processing) that were formerly part of Headquarters activities.

The topic of transferring functions and funds from Headquarters was discussed extensively among the IHDT. We concluded that if a function exists primarily to support the field, then that function, together with control and responsibility for associated resources, should be transferred to the field. However, those funds earmarked by the Congress for particular purposes must be used only as they are earmarked even if they are transferred to field control.

The transfer of control of more resources to Area Offices is a good first step, but we think that control of resources ultimately should be passed to I/T/Us when practical. We set a minimum goal of 25 percent of resources to go to the local I/T/Us. We made this goal flexible to accommodate the functions that Areas and I/T/Us actually choose to perform for themselves.

What happens to $ from FTE reductions?

Headquarters has reduced staff on payroll by 255 since 1993. If not downsized by this number, Headquarters payroll would be $15.3 million more than it is currently. Is the full amount available for the field?

No. The IHS budget for administration was reduced by the Congress by about $4 million. Staff were reduced, primarily through attrition, about equally between Headquarters and Areas to absorb these cuts.

Meanwhile, costs increased due to inflation during this period. Staff reductions and other cuts were taken about equally between Headquarters and Areas to prevent overspending the available budget. In other words, the number of on board staff has declined by 34 percent, but costs did not decline by a proportionate amount.

As some tribes elected to assume responsibility for eligible headquarters components, associated resources were transferred. In FY 1996, about $18 million was transferred to tribal contracts and compacts.

Regarding what to do with nation-wide I/T/U support components, we suggest placing them in a "center of excellence" at a suitable Area Office or I/T/U. If there is no agreement to retain a component to support all I/T/Us nation-wide, then transfer that function to Area Offices and distribute the associated resources among them proportionately.

On the whole, the proposals that transfer routine operational matters to the Area are a move in the right direction although a number of details remain to be resolved.

New Core Functions

The IHDT has given Headquarters new core functions that are very important for our new IHS. Because most of the resources for Indian health comes from the federal government, it is vital that IHS Headquarters advocate for Indian health, advance our community based approach, support a nation-wide Indian health network, document our health needs, and furnish a strong voice for tribes and Indian people.

We expect that routine oversight functions will be delegated to the field. We think there will be reduced Headquarters control responsibilities and more effort to offer choices at the I/T/U level through a nation-wide network that links I/T/Us together.

The final meeting of the full IHDT was held in October, 1996 to review Headquarters progress towards our design goals and to consider adjustments to recommendations based on the feedback obtained from Indian Country during the preceding months. The following positions were adopted.

Schedule for Completing Headquarters Restructuring

Headquarters restructuring will move forward on the schedules presented below.

New Headquarters Structure: 1997 Schedule

9/30/96	**HQ Core Structure Formulated**
10/9/96	**Update to IHDT on Phase I**
11/1/96	**Director Approves HQ Restructuring Package and Federal Register notice (effective: 3/1/97)**
12/1/96	**Director designates interim management for new offices OMS and OPH**
1/1/97	**Personnel processes and discussions with Unions**
2/1/97	**Complete personnel actions and discussions/ negotiations with Unions**
3/1/97	**Implement New HQ Structure**

Headquarters Resource & FTE Transfer: 1997 Schedule

9/30/96	**Options for transferring public health support**
11/1/96	**Send options to Areas**
11/13/96	**Headquarters review options**
12/10/96	**Area feedback on options**
1/13/97	**Clinical leader feedback on options**
2/28/97	**Complete negotiations with Areas/I/T/Us, and unions**
3/15/97	**Options selected and communicated to ELG**
4/15/97	**Complete initial personnel actions**
5/15/97	**Begin implementation**
8/30/97	**Resource transfer completed**

Additional Guidance for Transferring Headquarters Components

1. To promote effective Public Health Core functions, the IHS shall retain capacity to:
    - Assess changing health needs of Indian people,
    - Determine the amount of resources that are needed to address those needs,
    - Assist I/T/Us, as requested, to develop effective strategies to meet those needs.
2. When developing proposals to transfer Headquarters components to Areas, Headquarters shall consult with Areas. Areas shall consult with Tribes, Urban Indian Health Programs, and I/T/Us about the impact of such changes.

A bigger voice together - an example -

The IHS negotiated a 40 percent increase in the Medicare and Medicaid (M&M) reimbursement rates in 1996. The higher rates will increase revenue to IHS and tribal health programs by about $65 million annually and will help cover the higher costs of providing services to M&M beneficiaries.

This is an example of Headquarters acting with unified voice for local federal and tribal health care delivery sites for something that the I/T/Us could not have achieved by working separately. We thank the IHS Business Plan Workgroup for leading the successful negotiations that resulted in the increased rates.

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Chapter

4

CHANGES AT THE AREA LEVEL

The redesign efforts for Area Offices have not progressed as far as the Headquarters components. Area Office restructuring is not expected to be completed until 1998. In our November 1995 report, we recommended changes for Area Offices including consolidation of some components into regional support centers. In 1996, the IHDT asked Area Offices to conduct workshops with I/T/Us and tribal leaders regarding these proposed changes. The recommendations for regional support centers were not supported widely by workshop participants. This chapter offers some alternatives for restructuring Area level work.

Initial Recommendations and Update

We heard directly from Tribal and Indian health leaders when we held the Tribal Leaders Forum in February 1996 in Albuquerque. Approximately 90 persons attended and 17 gave formal testimony to us. As a result of their feedback, we began a process to get direct participation of I/T/Us, tribes, and communities for making changes to the Area Offices. We initially recommended the following changes for Area Offices:

- Delegate management and program authorities to I/T/Us for more local control and accountability (accepted)
- Transfer resources to I/T/Us for those functions that I/T/Us determine they should do for themselves - we set a goal of 25 percent (accepted)
- Change Area Offices from overseers to suppliers of support services to the I/T/Us (accepted)
- Consolidate support activities among Area Offices into regional support centers to maintain the economies of scale needed to support to I/T/Us (not accepted, in discussion)
- Reorganize program support staff into cross-disciplinary teams (accepted, in discussion)
- Finance support services by service fees negotiated with I/T/Us (accepted, in discussion)
- Invest redirected resources into patient and community health services (accepted)

Area Workshop Results

We asked that all 12 IHS Areas hold workshops to get ideas for changes in their Areas. Leaders from tribes, Indian communities, and I/T/Us participated in the workshops and developed recommendations on how to restructure Area Offices.

The Area workshop results show a wide diversity of recommendations. With conditions and methods of delivery varying from Area to Area, the views on how to restructure Area Offices are varied, too. Workshop participants from each Area identified a different mix of needed support services. The ways to supply them are different, too. For example, the Aberdeen Area workshop participants want to keep all support services at their existing Area Office. The Alaska Area proposes transferring all Area functions, except residual, to a state-wide tribal consortium. The Navajo Area workshop participants are considering integrating the Bureau of Indian Affairs, the IHS and other state and federal activities into one service center. Workshop participants had different ideas about which functions would be good to consolidate and which ones the I/T/Us should do for themselves.

Changes at Areas are underway already!

These changes are in response to forces such as budget limits, rising costs, transfer of functions and resources to contracts and compacts, and different needs in the I/T/Us. For example:

Significant proportions of functions in the Portland, Bemidji, and California Area Offices have been transferred to tribal compacts and contracts. Adding the other forces have resulted in downsizing these Area Offices including use of RIF (reduction in force).

None of the tribes in the Albuquerque Area has elected self-governance at present, but the Area has completed major restructuring that has reduced Area staff from 240 to about 130. This restructuring also included redeployment of Area functions and staff to service units.

The Alaska Area is in the midst of creating a state-wide tribally operated consortium to perform Area Office type functions for I/T/Us in Alaska. For the first time, a tribal consortium will operate a regional referral center serving multiple I/T/Us - the new Alaska Native Medical Center located in Anchorage.

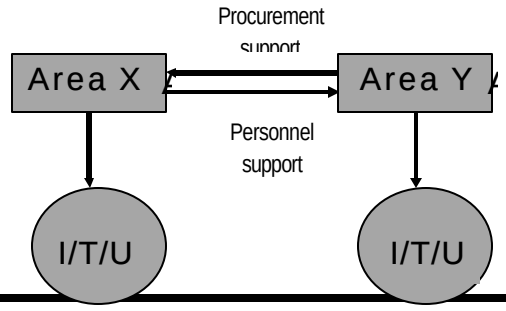
There is support for keeping 12 Area Offices. While workshop participants identified problems with Area Offices, they valued Area Offices as a point of access, for familiar working relationships, and for expertise on local health issues. They identified Area components that are no longer a priority for I/T/Us and components that would be better performed at the I/T/U.

From the workshops, we learned that consolidating Area Offices was not supported widely--especially if consolidation was imposed. Only four workshops consider regional support centers as a way to supply some, but not all, Area level support functions.

We understand your concerns about consolidating Area Offices. We conclude that there is no support for across-the-board consolidation into the proposed regional support centers. Your feedback does indicate some support for the "center of excellence" proposal. We have heard your message about the wide diversity of communities, circumstances, and values. We understand the need to respond to these differences, not with a "one size fits all" solution, but with flexible alternatives. Your feedback tells us that you think change should come from local ideas and not from the top or from somewhere else - even if that is a group of us called the IHDT. Most of all, we have heard your message about your desire to own the process by participating fully in making changes that affect your health care.

Area Cooperation and Backup - an example -

Area Offices can arrange to share capabilities through cross-servicing agreements for mutual benefit. For instance, Area Office X could supply personnel support to I/T/Us located in Area Y. In return, through a cross-servicing arrangement, Area Office Y could supply procurement support to I/T/Us located in Area X. In this way, the I/T/Us in both Areas realize the benefits gained from sharing and backup.



The IHDT will not impose regional support centers. However, because of the forces that are making it difficult to sustain full capability at each Area, we will offer recommendations for other ways to restructure this work.

We are committed to a new IHS in which the basic building block is the I/T/U. All else is geared to support the I/T/U. We have identified a framework for you to use as you restructure your Area Offices into a supplier of services to I/T/Us. These are provided to get you started on making the changes at your Area level.

Revised Recommendations for Area Restructuring

1) ***The IHDT does not recommend consolidation of Area Offices into regional support centers.*** This does not mean that Area Offices will continue exactly as they are today. Already many changes are underway. We see the need for additional cooperative arrangements among Area Offices to backup one another.

2) ***The support services supplied by an Area Office should be determined through a local process involving the I/T/Us.*** I/T/Us

should have a strong voice in the process to improve the mix of services supplied by Area Offices to meet I/T/U needs and priorities. I/T/Us may choose to eliminate some support functions, expand others, or obtain them from another Area Office or outside source. We think a good way to begin is to reorganize Area professional consultants into cross-disciplinary teams as we recommend in our November 1995 report.

3) ***Area Offices should cooperate with other Area Offices to supply those support services that each has trouble doing alone.*** In our November 1995 report, we conclude that downsizing in some Areas is making it difficult to maintain a full complement of support services to I/T/Us. We recognized that some sharing of capabilities and backup among Area Offices would be necessary. However, we understand that imposing a "one-size fits all" regional support center model is not an acceptable solution. A more flexible approach is needed. We recommend that Areas jointly set up cooperative arrangements for work as practical and beneficial. This approach would preserve an Area Office presence that most tribes found useful, while allowing alternatives ways to get needed work done more cost effectively.

4) ***Area Offices may jointly form centers of excellence where practical.*** A center of excellence is a term for a shared component that benefits more than one Area and which is usually developed from an existing site or organization that offers special expertise. IHDT members identified a number of instances in which several Areas now collaborate to share services to more fully serve all I/T/Us in the region. The IHDT encourages Area Indian health leaders to explore the opportunity to make these and other components into centers of excellence if it works for them.

5) ***Area Offices should transfer to the I/T/U that work that is better done at the I/T/U level.*** How quickly this occurs depends on capability at the local program and also on when the Indian health network becomes fully operational. In our November 1995 report, we established a minimum goal of 25 percent for reallocation to I/T/Us. We set this goal to further highlight the principle of decentralizing control of resources. We recognize that this goal must be flexible to accommodate differences in capability at I/T/Us.

6) ***Each I/T/U may arrange support services from any Area Office or other source that meets its needs at a reasonable cost.*** The major change is that officials at the local Indian health facility will have more options for getting needed support services and more control over where to get them. When all the changes in the support system are completed, local staff will be free to shop for needed support from any acceptable source that meets the need at an affordable cost. The expanded options gives the I/T/U more flexibility to respond to the needs of the local community.

7) ***Invest in nation-wide Indian Health Network.*** Advanced communications technology makes it possible to link all I/T/Us together. A nation-wide network that offers possibilities to share capabilities among I/T/Us and Area Offices is one way to reduce rising costs. Connecting I/T/Us allows them to use services available anywhere in the network, not just on-site and from one Area Office. The limits of

geographic location become less important and dependence on one source is reduced. In this way, Indian health programs can realize the benefits of cooperation, and gain flexibility to fit local needs. The technology to do this exists. Investment in a nation-wide Indian health network is essential to achieving a level of collaboration necessary to offset risks related to size and geographic isolation.

Additional Guidance for Area Office Restructuring

During the final meeting, IHDT members from different geographic regions were grouped to explore opportunities for cooperation among Areas. The groups examined prospects for using a local tribal-guided process in restructuring Area level components. The goal was to identify Area level components that might be more cost effective if shared.

The sub-groups reported instances in which Areas already jointly support a service that could not be provided by the Areas acting alone. Some examples of cooperative shared services are specialty medical services, legal support, third party billing, certain contracting functions, epidemiology, recruitment, and youth treatment centers. We were encouraged to find a basis for additional inter-Area cooperation. We approved the following recommendations as a guide for restructuring Area level components through a local tribal-guided process.

Each Area is requested to:

1. Participate by 4/30/97 in inter-Area workshops to identify opportunities for cooperation on Area level components that are not cost effective if continued separately. These sessions should include Area Offices, Area Health Boards, Tribal Organizations, and officials from I/T/Us.

2. Develop by 9/30/97 a plan for inter-Area cooperation on those components for which cooperation is necessary, practical, and beneficial.

3. Prepare an implementation plan to be completed by the end of FY 1998.

4. The plans shall specify how critical administrative and public health support will be maintained to those Tribes that have not elected to contract and compact these functions.

Potential Legislative Issues

We identified a number of issues which need legislative action to resolve:

Budget simplification and flexibility – Existing Federal law and rules limit the amount of federal funds that may be reprogrammed to $500,000 for all of IHS. This constrains federal service unit managers that need to flexibly respond to rapid changes in local community needs and in the local health care market. Local managers need a simpler budget structure with more flexibility among line items.

Investment in the Indian health network – The redesigned IHS will consist of more autonomous individual I/T/Us that are less dependent on centralized support from one Area Office. This design allows I/T/Us to respond more quickly and flexibly to local Indian community needs. However, more local autonomy and less dependence also may increase

risks for smaller, geographically isolated I/T/Us. If individual I/T/U try to do everything alone, they face reduced economies of scale, higher operating costs, and more vulnerability in the competitive medical marketplace. These risks can be reduced if individual I/T/Us cooperate to share capabilities and buying power. The technology to do this exists. Investment in a nation-wide Indian health network is essential to achieving a level of collaboration necessary to offset risks related to small size and geographic isolation. To succeed in the new design, all I/T/Us must be connected in a telecommunications and information network that provides local access to shared capabilities available anywhere on the network. This vision can not be achieved with piecemeal funding obtained by restructuring. It requires leadership at the national level and across-the-board investment to connect all I/T/Us into a shared network.

Other Considerations and Unresolved Issues

A number of serious issues and concerns were raised during the course of deliberations which we could not resolve as part of the redesign of IHS. Some are long standing Indian health issues relating to equitable resource allocation, unmet funding needs, patient eligibility, self-determination contracting and compacting.

The IHDT did not take a formal position on these issues. We are aware of the diversity of opinion that exists in Indian Country about some of these issues. We believe that a broader forum, including participation by tribal governments, is needed to address them. Resolution for some of the issues may require changes in legislation and increased funding. Some of the more important unresolved issues that we identified are as follows:

1. Inadequate federal funding for Indian health programs.

2. Equitable funding for urban Indian health programs.

3. Federal government downsizing that could undermine federal obligations to tribes.

4. Uniform patient eligibility for IHS, Tribal, and Urban Indian health benefits.

5. Cost effectiveness and quality assurance issues for the smallest low volume hospitals.

6. Capability of I/T/Us to participate in state Medicaid managed care programs for Indians.

7. Concerns that the IHS is not moving rapidly to transfer resources to tribes that elect to operate IHS programs. Concerns on the other side that compacting weakens the IHS infrastructure supporting Indian health care programs.

8. Tribal leaders mandate that all savings gained from internal restructuring be retained for Indian health.

Chapter

5

URBAN INDIAN HEALTH

The American Indian Health Care Association, which represented a number of Urban Indian Health Centers, offered recommendations to the IHDT in it's draft report, "Urban Indian Health Redesign Recommendations." If you would like a copy of the draft report, please contact the American Indian Health Care Association in Denver, Colorado." A summary of recommendations from their report is listed below.

IHS Headquarters... *Transfer IHS, along with other federal programs serving American Indians, to a new Cabinet level department which deals specifically with Indian issues. Also establish a urban Indian presence in the Office of the Director, IHS.*

We did not take a formal position on Cabinet status for the IHS. The proposed IHS restructuring plan for Headquarters does include an urban Indian health program presence within the Office of the Director along with a presence for self-governance, tribal, and direct programs.

IHS Area Offices ... *Redraw IHS Areas to coincide with Federal regions to improve coordination, provide regular Title V training to staff, include urban representation on all standing IHS committees, and include urban representation on IHS Area Boards.*

We support increased dialogue and cooperation among all components of the Indian health systems - federal, tribal, and urban. Our recommended approach of a locally driven process for restructuring the IHS does not rule out these options, although redrawing Area boundaries appears to be impractical given other feedback that we received.

Urban Local Issues ... *Downsizing must not reduce support for urban programs. To encourage collaboration between urban programs and tribes, IHS should facilitate and help build bridges between urban and tribal providers, and eliminate regulatory barriers*.

Title V funding is earmarked by the Congress for urban Indian programs is not affected by proposed restructuring of Headquarters and Areas. While we support collaboration between urban programs and tribes, the IHS should not act as principal intermediary for sovereign Indian nations.

Technical Assistance ... *The IHS should contract with American Indian Health Care Association for provision of regular technical assistance to 34 urban programs.*

We did not take a position on any organization with which the IHS may contract.

IHS Eligibility ... *Reaffirm the original definition in Title V of the Indian Health Care Improvement Act. Urban programs seek proportionate funding to fully serve urban Indians.*

We acknowledge that federal health care funding for Indian people residing in urban areas is seriously inadequate. Many members of the IHDT consider patient eligibility and funding equity as possible legislative issues. The Congress could address funding for Urban Indians through increased Title V appropriations.

IHS User Population ... *Examine the urban Indian user population to determine the extent they are unserved or underserved and to ensure funds are proportionate.*

The funding for urban programs is authorized by Congress separately from other IHS appropriations. We acknowledge the unfunded health needs of Indian people in urban areas (while not forgetting the health needs of other Indian people that continue to go unfunded also).

I/T/U Equity ... *Ensure proportionate access to IHS categorical programs and health initiatives and identify "urban shares" of Headquarters and Area Offices.*

We have recommended Urban program access and participation in support services available from Area Offices (recommendation 1.11 in the original IHDT report). We did not take a position on proportionate "urban shares", but note that transfer of IHS functions to tribes is based on a statutory basis specific to federally recognized tribal governments.

Urban Program Data Systems ... *Overhaul the urban data system to make it compatible with the IHS system.*

Any overhaul of the urban data system should also contribute to the newly identified core function to maintain a "Indian health data bank". Such data are necessary to determine Indian health care needs and to advocate for the I/T/U system.

Patient Care Coordination & Linkages ... *Allow reciprocal referrals to improve patient coordination, make urban Indians eligible for CHS, and provide compensation for shifts in beneficiaries.*

Changes in patient eligibility would require Congressional action.

We considered the above recommendations and recognize that change is needed to improve the health of Indian people residing in cities and urban areas throughout the United States. We affirm the partnership with all 3 parts of the I/T/U concept, including urban Indian health programs. We ask you to consider how these recommendations may be included in the overall design of the Indian health care system and in the changes that you design within your Area.

Chapter
6

FEEDBACK AND EXPLANATION

The following table summarizes feedback that the IHDT has received regarding recommendations for Area level restructuring. The table summarizes a number of key comments. To save space, most of the comments are not listed verbatim. Our responses to the comments are not positions that were formally adopted by the IHDT, but are offered as further explanation of our views and intent.

Comment / Feedback	Response / Explanation
One comment proposed elevation of the Director, IHS to Assistant Secretary in the Department of Health and Human Services.	We did not take formal position on this recommendation. A number of IHDT members did express support for this concept.
Several comments support the IHDT commitment to meaningful tribal participation and proposes an ongoing consultation process after the IHDT ends.	The Director, IHS has stated his support for some form of continuing consultation and guidance from Indian leaders during implementation of the design changes. He noted that a sub-group of the IHDT might be workable now that the major initial design work is complete.
Several comments support restructuring and streamlining of Headquarters components.	We took action to continue Headquarters restructuring on the schedule shown in section "Schedule for Completion of Headquarters Restructuring".
One comment supports transfer from Headquarters to Area Offices of only those functions and FTE that are "necessary to operations in a redesigned Area Office." Resources associated with those functions should be transferred also. Relocation costs should not be paid by the Area Office.	We support this concept. On page 9 in Chapter 3, we state "if a function exists primarily to support the field, then that function, together with control and responsibility for associated resources, should be transferred to the field. . . . If there is no agreement to retain a function to support all I/T/Us nation-wide, then transfer that function to Area Offices and distribute the associated resources among them proportionately. We understand that the agency will pay relocation costs of redeployed components.
One comment seeks clarification about the lines of authority and role for national support components now located at Headquarters West in Albuquerque, NM.	The Headquarters reorganization package should identify functions and lines of authority for these components

Comment / Feedback	Response / Explanation
One comment says that Portland Area tribes offer little support for reducing the number of Area Offices or for mandatory regional support centers.	This comment is consistent with comment from tribes in other parts of the country, too. Our recommendations do not propose elimination of Area Offices or forced consolidation into regional support centers. However, locally determined sharing arrangements among Area Offices are recommended. Cooperation is a way to maintain cost effective support services to I/T/Us when full capacity at each Area Office becomes unsustainable.
Several comments support local tribal-guided restructuring of Area Offices and Area level components.	We did not recommend any single plan to restructure all IHS Areas. The diversity of needs and circumstances among the twelve Areas is too great for any single plan to succeed. That is why we endorse the concept of locally guided restructuring with consultation and participation of affected tribes, communities, and I/T/Us. We have offered a framework to guide Area restructuring toward goals cooperation while leaving the important details to be determined locally.
One comment did not support altering boundaries of IHS Areas to match Federal Regions.	We did not adopt a position on altering IHS Area boundaries. Our recommended approach of locally driven decision making does not rule out this option, although obtaining consensus to redraw Area boundaries appears to be impractical given other feedback that we have received.
One comment considers the recommendation in the draft report "Urban Indian Health Redesign Recommendations" for the IHS to act as principal agent to foster communications between tribes and urban programs as inappropriate. Tribes and urban Indian programs should look no further than themselves for this dialogue.	We support increased dialogue and cooperation among all components of the Indian health systems - federal, tribal, and urban. However, the IHS can not and should not act as intermediary for sovereign Indian nations.
One comment considers repeated requests in the draft report "Urban Indian Health Redesign Recommendations" for proportionate shares of IHS funding as masking a call for major redistribution of IHS resources which would be vigorously opposed by many tribes and which is not allowable under Public Law 93-638.	The present statutory basis for urban programs and direction from the Congress in appropriations Acts forbids significant redistribution of IHS resources for any purpose without first obtaining Congressional approval. The Congress should address funding for Urban Indians through increased Title V appropriations.
One comment proposed that IHS expand the Tucson Area Office to "full	All twelve Area Offices and Headquarters are downsizing. There are no additional resources to restore any Area Office to full capacity. The workshops held in each Area were

Comment / Feedback	Response / Explanation
service" capacity.	designed to explore ways to redesign Area components to make them more cost effective within the limited resources available. One way is to cooperate on components in order to reduce overhead and provide inter-Area backup.
One comment proposes that IHS retain and expand Headquarters components now located in Tucson as a Center for Training and Technology, fully integrated into the Tucson Area, but to be a national resource.	We endorsed centers of excellence (a term for a shared component that benefits several Areas or I/T/Us and which is usually developed around an existing site/organization that offers special expertise) if supported by I/T/Us. Given the special expertise of some components now at Tucson, the proposed center of excellence could succeed if the benefits are marketed to and supported by other Areas and I/T/Us. Our concept is that Areas and I/T/Us elect to participate in the center of excellence and agree to support it through cross-servicing arrangements or fees. We did not endorse mandates in which any Area or I/T/U is forced to participate and support involuntarily.
One comment opposes reorganization of Headquarters components now located in Tucson as subordinate to reorganized Headquarters components at Headquarters West. The comment says any reorganization of Headquarters components in Tucson contradicts the spirit of Indian self-determination and desires expressed by Tucson I/T/U.	The majority of comments from tribes support reorganization and streamlining of Headquarters components. Headquarters components, whether they are located in Rockville, MD or at any other geographic location, exist for and are shared in common by all I/T/Us nation-wide. Reorganization of Headquarters components is best done considering input of all tribes and I/T/Us. We also adopted the concept of local tribal-guided reorganization for Area level components to assure participation in restructuring these components.
One comment proposes institutionalizing the former American Indian Health Care Association with a line item budget similar to the National Indian Health Board.	We did not take a position regarding any organization with which the IHS may contract or fund. The Director has stated that a single umbrella organization that broadly represents all Indian people, whether served by IHS directly, by a tribal operated program, or by an urban Indian program is a good way to promote cooperation.
One comment proposes an urban Indian programs presence in the reorganized office of the Director.	The proposed IHS restructuring plan for Headquarters does include an urban Indian health program presence within the Office of the Director along with a presence for self-governance, tribal, and direct programs.
One comment proposes that Indian Health Services Headquarters remain in Rockville, MD.	Neither the IHDT nor the IHS has proposed relocating core Headquarters functions away from the current location in Rockville, MD.
One comment supports continuation of the Bemidji Area Office to provide support to IHS service units and opposes creation of a separate field office for Minnesota as unnecessary duplication.	We do not call for closure of Area Offices, but we acknowledge that Area Offices will continue to change given resource limits and additional transfers of Area components to tribes. Our proposal for a locally guided restructuring process is a way to resolve local issues like this.

Comment / Feedback	Response / Explanation
Several comments support the IHDT principles to transfer functions to I/T/Us that are practical for them to perform.	These principles and recommendations are stated in the original IHDT report distributed in November, 1995.
One comment supports flexibility to reprogram at least 25% of budget line items by IHS service units.	Self-determination compacts enjoy the flexibility to redesign programs and focus resources on new priorities. This flexibility is a major advantage compared to IHS operated service units. Federal law limits the amount of funds that can be reprogrammed by the IHS to $500,000 for the whole of IHS. Additional reprogramming flexibility for federally operated service units may require a legislative solution. The IHDT notes that the IHS Business Plan Work Group proposed a simplified budget structure for the IHS that would collapse some line items thereby providing some additional budget flexibility. This proposal is under discussion with relevant Congressional committees.
One comment asserts that standards and guidance are necessary for setting up local governing boards as proposed by the IHDT.	We did not define specific standards in our recommendation for local "Health Partnership Boards" (recommendation 1.3 in our November 1995 report) other than specifying that residents in the local Indian community should be included. Perhaps a subsequent group can further define standards and establish a process to develop appropriate standards.
Several comments stated that the Aberdeen Area Tribal Chairmen's Health Board does not support the reorganization process advocated by the IHDT. It supports retaining the Area Office concept in Aberdeen Area. The comment asserts that regional support centers would negatively impact "non-compacting tribes".	We received similar comments on our initial recommendations to form regional support centers. Because of these comments, we revised our approach to Area level restructuring and recommended a local tribal-guided redesign process for Area level components. The revised approach is outlined in Chapter 4 of this report.
Several comments assert that Aberdeen Area tribes, which are not compacting, experience "adverse impacts" from extensive compacting in other IHS Areas.	Restructuring other Areas Offices will not directly affect Aberdeen Area because Aberdeen Area shares few resources in common with most other Areas. Of course, Aberdeen Area does share IHS Headquarters components in common with other tribes. When any tribe takes their share of Headquarters components, shares for all other tribes are retained on their behalf. To document this, IHS plans to publish, by the end of FY 1997, a detailed report to all 550+ tribes that identifies each tribe's potential shares of IHS resources at all three levels - local, area, national. The report also will show whether the resources are transferred to the tribe or retained by IHS on the tribes behalf. The negative impacts of downsizing cited above are caused by a number of factors -- a IHS budget that has not kept pace with rising costs, lost buying power, and restrictions placed

Comment / Feedback	Response / Explanation
	on IHS by acts of Congress. These impacts are experienced in other Areas in addition to changes resulting from transfer of Area components to compacts.
One comment asserts that FTE reductions in Aberdeen Area are not fair because of less compacting in Aberdeen Area. The comment proposes that excess FTE should be directed to non-compacting Areas.	FTE restrictions were placed on IHS as a result of limits on Federal employment set by the Congress. See Public Laws 103-356, 103-324, and 103-62 for reforms that affect the IHS. FTE limits were assigned to each IHS Area in proportion to Area employment with adjustments for staff for new facilities. The FTE limits are a form of hiring restriction. They limit employment but do not reduce funding. If excess employment "slots" are created by employment downsizing at the Area Office, IHS should consider reallocating FTE slots to service units that continue to rely on federal employees. Most IHDT members would support redirection, first to service units within the Area that may need and can afford additional staff, and then to I/T/Us in other Areas. If FTE slots are reallocated among Areas, this should not reduce the budget of the Area Office that contributed the slots or increase the budget of the Area Office that receives the FTE slots.
One comment asserts that there has been no tangible enhancement of services as a result reorganization and that there is not a genuine intent to redeploy resources or FTE to the local level.	Originally, we proposed consolidating functions from Area Offices and Headquarters into regional support centers as a way to economize. Any savings realized from restructuring was to be redirected to the local I/T/U level. Potential savings of 25 percent as a result of consolidations was identified in the November 1995 report (figure 28 on page 53). Tribes opposed consolidating Area Offices into regional support centers. Without the economies gained from consolidation, savings will vary depending on the extent to which Area components are restructured or transferred to I/T/Us.
One comment asserts that "re-designations" and name changes for Headquarters components is a disguise for cost shifting to Areas.	Certain budgets managed by Headquarters have traditionally paid the costs of support services that were not directly charged to Areas and I/T/U (e.g., rent, communications, construction, recruitment, technical assistance and training, and information/computer development and processing, etc.). These funds are often spent at the Area or local level, but were reported in Headquarters accounts. Under the Headquarters restructuring plan, only resources associated with core Headquarters functions will be included in the Headquarters budget. The balance of funds are for nation-wide public health support activities, or will be transferred to Area Office control based on costs actually incurred, or will be transferred to tribal compacts and contracts as they elect to assume responsibility for Headquarters components. These changes will more accurately show how resources have been actually used. We are concerned about the possibility of Congressional directives to cut IHS

Comment / Feedback	Response / Explanation
	central office budgets as happened at the Bureau of Indian Affairs, especially since 85 percent of the Headquarters budget pays for critical health care support functions in the field. We believe that accounting for costs of field support separately from Headquarters, will help preserve these critical resources from potential cuts that might occur if they are linked to Headquarters.
One comment seeks assurance that no adverse impact to Aberdeen tribes will occur as a result of restructuring outside Aberdeen Area.	We support the local tribal-guided process for Area level restructuring. Restructuring of other Areas will not directly affect Aberdeen Area because most other Areas share few resources in common with Aberdeen Area. An exception is with the Bemidji Area, with which Aberdeen shares a limited number of accounting functions. All Areas are encouraged to participate in cooperative arrangements if that is feasible and beneficial.
One comment says that the Aberdeen Tribal Chairmen's Health Board sees no justification for Headquarters West operations to continue at the present level.	We agree that restructuring of national I/T/U support and Headquarters components, which Aberdeen Area shares in common with eleven other Areas, is necessary. The IHDT supports the idea that the field and Areas will determine whether certain national support components will continue and in what form. We state on page 8 of this report that "If there is no agreement to retain a Headquarters function for the support of all I/T/Us collectively, then transfer that function to Area Offices and distribute the associated resources among them proportionately."
One comment questions whether reduced reimbursement for health professions "special pay" are the result of payments to compacting tribes.	Every tribe's share of Headquarters resources, including the resources to reimburse health professions special pay costs, are retained for that purpose unless the tribe elects to assume that responsibility under a compact or contract. Independent of contracting, however, requests to Headquarters for reimbursement of special pay costs has exceeded the funds available. For this reason, reimbursements to each Area only partially met the need. However, this question highlights a change that we seek. Concerns about fairness in how Headquarters reimburses Area costs would be eliminated if these resources were transferred to the Areas to manage directly.